How About Investing a Little Bit More in the Bloody Approach?

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Last year Prof Gurman initiated the publication in our journal of a series of happenings in the field of anesthesia and intensive care. They escalated to an unwanted outcome and the end of every story was decided in the courtroom. This is why the medical cases turned into legal cases.

There is no happy end to a legal case except for the patient to recover and the doctors to acknowledge their good faith and flawless professional behavior. Still, if some wisdom issues from a legal case, there is a positive reflection one can use later on.

The comments an anesthetist would immediately formulate after confrontation with such a case would be self defendant, and in no case neutral. And the best defense is evidence-based.

When trying to find medical evidence for radial nerve palsy on the net, the first results the Google offered where 583000 entries. When adding anesthesia, the figure dropped to 237000 and further to 2940 if filtered with an additional noun, positioning. Thus medical literature referring to the reported case is not exotic, and yet few of the titles red and of the articles studied consecutively were relevant to the subject of the research.

Anesthesia charts have to be explicit enough to insert the position of the patient on the operating table, stated the judge in Prof Gurman's case report. As it resulted from the chart, there were two repositionings of the patient during surgery. But this would augment the numerous details one is supposed to insert in an anesthesia chart. Still, the operating procedure detailed as due contains always the position of the patient on the operating table. Is it compulsory to double written information, such as positioning on the operating table, or should one finally reconcile all the data concerning the patient so as not to neglect any information, but still, not unduly repeat it? Perhaps it is time to come up with a uniform medical file inserting all the important data, such as those from the passports or other IDs. Every surgery case undergoing anesthesia takes several players into account. Why then blame this case only on the anesthetists? At the end of the day this was a team approached case and as such, a team failure.

Moreover, there are reports on the damage a retractor, specifically the Kent retractor can produce during upper abdominal surgery [1]. The potential deleterious effects of a tourniquet on the radial nerve are well known, but also the damage due to compression against the anesthesia bar [2,3]. Similarly, the "prolonged application of a tourniquet to the arm of a person with a slender triceps muscle is followed by temporary radial palsy"[4]. Overweight did not help since at the vulnerable part of the radial nerve the fat layer is discrete. Should we blame on the added compression exerted at the level of the spiral groove the radial nerve travels due to one of the surgeons, since it could be incriminated [5]? It might also be that a frail triceps muscle plus prolonged compression – surgery did not last but for 80 minutes – were too much for the nerve to recover.

To sum up, there were at least three factors contributing to radial nerve palsy, but since it occurred only at the arm with the blood pressure cuff, we think that by far the pressure developed in the cuff overlapped the one exerted by other external effectors. And blood pressure monitoring is a standard of care during anesthesia. Excessive cycling when inflating the cuff is not to be considered since the registered and reported interval blood pressure was monitored was 10 minutes. The head-down position twice for fifteen minutes surely did not help since usually the patients tend to slide down and further compress with the arms the anesthesia bar.

We as doctors, we have a duty towards our patients. Was there a breach of duty in the sense that informed consent somehow failed to mention the unforeseen risks of a joint anesthesia and surgery approach? In fact, the damaged part was the invalidated patient who received some kind of reward for being hurt, which is sensible. On the other hand, the surgery team was as it lately came out, oversized. What if the hands of the patient would have been kept by his side, wrapped in drapes and the iv lines provided with proper extensions so as to be reached by the anesthetist?

Surely the risks to the patient would have been diminished. But for the costs… The anesthetists and surgeons followed a positioning protocol arising from the general medical practice and adopted by their hospital. May be sticking to a protocol, no matter on what problem is not always the best medical approach and flexibility as to particular conditions should demand adapting the protocol. Perhaps just for an oversized team of surgeons, to avoid the deleterious effects of overcrowding around the patient, investment into intravenous line extensions would have avoided the unwanted radial palsy. Surely a cost efficiency study would be able to demonstrate that intravenous line extensions are not compulsory, that they would add to the risks of the patients, such as disconnections, and that the investment would not be justified. But for these damaged patients?

Were it not for being materially satisfied, would the plaintiff's demand be less important?

I am sure that such cases benefit from a larger debate and that several opinions would add value to taking positions in the aim of problem solving. On the other hand, the same problem judged in different countries would have different outcomes. "One size fits all" as it always a debatable issue. The way the complaint was silenced demonstrates the wise approach of the judge who facing a damaged patient had to give him satisfaction, and in doing so, to navigate between a common sense expert opinion of the plaintiff's expert and the evidence advocated for by the defendant's expert. The plaintiff's expert focused on the anesthesia chart not mentioning the position of the patient's arms on the operating table, but when you have no iv extensions, what could that position be? The evidence he evoked in his support was based on documents issued by the ASA (American Society of Anesthesia). Still, if these documents are not fully endorsed by one's own professional society, can they be used as enforcing arguments?

The fact that this editorial raises more questions then offers answers points on the complexity of ethical issues mirrored in legal cases. Is seems that the radial palsy in the presented case was deemed as a collateral damage, since the patient survived and his digestive problem was solved. Money as accepted by the patients was an acceptable damage cover. But did this lead to any change in the policy of the hospital?

The bloody approach is the riskier one could think of in trying to manage a medical problem. In other words, surgery is risky and anesthesia is by no means a smooth journey for the anesthetist. But the patient needs to be safe.

This is why I size down the problems issued from the anesthesia-surgery team approach to rationing on the amount invested in patient safety.

References

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